New patient intake form

KP# _______________

Office Use only			**Patient account number**
Past patient: ☐ **YES** ☐ **NO**	Evaluation date/ Time / Therapist:		#
Diagnosis 1 (Desc/ ICD9)	Diagnosis 2 (Desc/ ICD9)	Financial Class:	☐ PT OT ☐ Other

Patient Information			
Patient Name: (Sr., Jr., etc) First MI Last			SS #:
Address:	City:	State:	Zip Code:
Home and Cell #: ____________________________ Email (**imp**):	**Date of birth** (mm/dd/yy)	Status: ☐ Single ☐ Married ☐Unknown Sex: ☐M ☐F __ Other	
Original Date of Injury: Onset date: ___/___/___	**Auto Related** ☐ Yes – State? ☐ No	**Work Related** ☐ Yes ☐ No	**KP Adjustor Name, Telephone & Address**

If Workers comp:
Have you received Therapy treatment for this condition since the above "Original Date of Injury"? ☐Yes ☐ No
Of so, how many treatment sessions do you remember receiving? ___________________

If Workers comp, was accident with present Employer? ☐Yes ☐ No If No, who was the employer?	**If workers comp, case worker Name and telephone #**

KP Insurance Information		
Insurance Company Name	Policy or Claim #:	Group# :
Policy Holder's Name:	**Date of Birth** (if other than self)	**Patient relationship to policy holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other
Insurance telephone #:	Policy Holder's Work phone:	Policy Holder's Employer:

Secondary Insurance Information (Backup if Auto, Workers Comp. Or Litigation)		
Insurance Company Name	Policy or Claim #:	Group# :
Policy Holder's Name:	**Date of Birth** (if other than self)	**Patient relationship to policy holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information			
Employer Name:	Employer Phone:	Employment Status: ☐None ☐FT ☐PT ☐Self-Emp. ☐ Disabled: __ total __Temp ☐Retired ☐Student	
Address:	City:	State:	Zip Code:

Emergency contact Information		
Contact Name:	Phone #:	Relationship to patient: ☐Parent ☐Spouse ☐Sibling ☐Other

Physician Information			
Name of Referring Physician:	Telephone and Email:	UPIN#	
Address:	City:	State:	Zip Code:

Attorney Information			
Attorney name:	Telephone#:	Fax # :	
Address:	City:	State:	Zip Code:

Hands-on-Care

Specializing in Shoulder, Elbow, Wrist and Hand Therapy

Patient: ________________________________ **EVAL. DATE: _____________**

Are you presently working: ____ Yes ____No Date of Next Physicians Visit: ________________

Date of Injury/ Onset: ___________________ Have you ever had these symptoms before?: ____ Yes ____No

Check which apply to your symptoms: ___Work related injury, ___Recurrence of previous injury, ___Motor Vehicle accident, ___ Injury related to lifting, ____Cause unknown, ____Athletic / Recreational injury, Injury Related to falling, ___ Other: ________

Have you had related surgery: ____ Yes ____No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes			Allergies to Asprin		
Chest Pain / Angina			Allergies to Heat		
High Blood Pressure			Allergies / Poor tolerance to Cold		
Heart Disease			Other Allergies		
Heart Attack			Hernia		
Heart Palpitations			Seizures		
Pacemaker			Metal Implants		
Headaches			Dizziness / Fainting		
Kidney Problems			Recent Fractures		
Are you pregnant?			Surgeries		
Cancer			Skin Abnormalities		
Osteoporosis			Sexual Dysfunction		
Bowel / Bladder Abnormalities			Nausea / Vomiting		
Urine Leakage			Ringing in your ears		
Asthma / Breathing Difficulties			Rheumatoid Arthritis		
Liver / Gallbladder Problems			Special Diet Guidelines		
Smoking			Hypoglycemia		
Stroke/CVA			Other:		

If yes on any of the above, please briefly explain and give approximated date:

____

Is there any other information regarding your past medical history that we should know about?

____

Are you presently taking Medication? __ Yes __ No __ See attached list

____

If yes, please list what medications and for what condition:

____

Patient Attendance Policy for all Insurances

It is our policy at Hands-On-Care to give prompt, courteous service to all our patients. In order for us to deliver service in this manner, we schedule individual appointments. We try to schedule these appointments so that they are convenient to you. It is important for you to arrange your schedule so that you can be on time for these appointments.

If you are unable to attend or you will be late for you appointment, please notify the center in advance. If necessary, at that time you can reschedule the missed appointment. Failure to attend your session may hinder your recovery process. By notifying the center in advance if you cannot keep your appointment, or if you will be late, we are able to rearrange our schedule to accommodate you as well as other patients.

☐ 24-Hour Advance Notice Fee: **If you wish to change or cancel an appointment we require a minimum** *24-hour advance notice.* **Anything less will result in a *$50 fee* charged to your account. It costs us money to make appointments available to you whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere *$50 fee*. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.**

☐ Late Policy "10-minutes": **Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.** If you arrive later than 10 mins past your scheduled appointment a **$25 fee** will apply.

☐ No-shows are bad: **If you fail to show for an appointment without notice all future appointments will be removed and a *$50 fee* assessed to your account. You may re-schedule appointments again on a "*first come, first serve basis*".**

☐ Cell phones must be shut OFF or silent: **We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.**

☐ Children requiring supervision are NOT allowed to attend sessions with you: **Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to termina[1] your session early and attend to your child.**

☐ Courtesy Reminder: As a courtesy to you, we provide you with 2 phone calls and 1 email to remind you to schedule your appointment, after that we inform your physician or workers comp adjuster and discharge you from therapy.

____

Signature

Worker's Compensation ONLY Patient Attendance Policy

If you are covered by worker's compensation insurance and you fail to keep the appointments that are recommended by your therapist and physician, **the appropriate parties need to be notified to your absence** and will also be noted in your chart. This may include your physician, employer, insurance company, and case manager/rehabilitation nurse. Please understand that failure to actively participate in your rehabilitation program may have a negative effect on your worker's compensation coverage.

Thank you for you assistance.

I have read and understand the above. I understand that attendance at each therapy session is important to my recovery and will notify my therapist if unable to attend a session so that it may be rescheduled.

Patient Signature ______________________________ Date___________________ Or,

Parent/Guardian _______________________________ Date ___________________

For each no-show are cancelled visit, doctors, employers, and workman's compensation will be notified. Two no-shows and/or three cancelled visits will result in discharge from therapy and/ or you may be requiring an appointment with your physician for a new prescription. You may be charged for a fee for a no show or cancellation.

We hope you take your therapy and recovery as seriously as we do.

Por cada visita cancelada se notificara a su doctor, empleadores, y su sueguro de compensacion de trabajadores. Dos faltas y/o tres visitas canceladas resultara en el cierre de su tratamiento. Esperamos que tome su terapia su recuperacion tan serio como nosotros lo tomamos.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("**HIPPA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have knowledge of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information available online at http://www.hocinc.us/pdf/NOTICE_OF_PRIVACY_PRACTICES1.pdf . I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Relationship to Patient : ______________________

Signature: ____

Date: / /

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: / /

Initial: ____

Reason: ____

BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility or the Central Billing Office to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize Hands-On-Care to disclose my health information that is directly related to my current treatment at Hands-On-Care to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name	Relationship

I do not wish to have my health information disclosed to individuals involved in my care.

Name	Relationship

____ ______________

Signature of Patient (Or patients representative) **Date:**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

____ Power of Attorney, ___ Guardian, ___ Surrogate Decision-Maker, ____ Parent, ___ Other (please specify): ____________________ Executor of Legal Rep ________________

Provide documentation or explanation of your authority to act for the patient:

____

____

____

____

____

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☐ **SUPPLIES**: Payment for all supplies not covered by insurance is due at the time of service. Kaiser covers only Medicare allowables

MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible for payment for all supplies used in your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. We will file your insurance for payment for your convenience, however, the final payment if your responsibility. Please be aware of this and plan to make payments accordingly.

WORKER'S COMPENSATION benefits will be verified for your convenience.

☐ **FINANCIAL HARDSHIP**

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**

"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments ... even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This include; services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute. Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128A(a)(5)of the Health Insurance Portability and Accountability Act of 1996 [section 231 (h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building. 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector Gener, 202619-0089."

☐ **Usual and Customary Rates**

Our practice is committed to providing the best treatment to our patients. We charge no more than usual and customary for our area, and frequently less. You are responsible for payment regardless of what your insurance company calls "usual and customary" rates.

☐ **Minor Patients**

The adult accompanying a minor or the parent/guardian of the minor is responsible for the patient portion (if any) due at the time services are rendered. Be aware that the parent/guardian must sign a Consent to treat Minor.

☐ **Treatment Consent**

I understand that I have been referred for rehabilitative treatment and care to a Hands-On-Care Outpatient Rehabilitation Center. Hands-On-Care has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. **By signing this agreement, I consent to have Hands-On-Care Outpatient Rehabilitation provide treatment and care as prescribed by my physician and/or recommended by my therapist.**

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Hands-On-Care Outpatient Rehabilitation. I hereby authorize Hands-On-Care Outpatient Rehabilitation to furnish my insurance company(s), attorney, or legal representative all information which said parties might request concerning my present illness or injury. I hereby assign Hands-On-Care Outpatient Rehabilitation all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Hands-On-Care Outpatient Rehabilitation. It is understood that any money received from the insurance parties over & above my indebtedness will be refunded to me when my bill is paid in full. ***I am financially responsible to Hands-On-Care Outpatient Rehabilitation for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.***

☐ I understand that I may be financially responsible for payment of all charges for services rendered to me, including the balance remaining after payment of insurance benefits not covered by Kaiser Permanante. I authorize payment of medical benefits to Hands-On-care. I authorize release of any medical information or records to the insurance company for the purpose of payment. I authorize release of my medical records to my doctor for continuity of care.

Specializing in Shoulder, Elbow, Wrist and Hand Therapy

Patient: ______________________________ EVAL. DATE: ___________

FUNCTIONAL GOAL FORM

This is required by Medicare and many insurance companies to prove that you need treatment. Please assist us with this.

PAIN:

Please indicate the amount of pain you experience from the injury. **Zero being No pain and 10 being emergency room pain.**

Mark the Pain at **Rest**:

0________1________2________3________4_________5_________6_________7_________8_________9_________10

No Pain Mild Moderate Severe Emergency Room

Mark the Pain **on Average**:

0________1________2________3________4_________5_________6_________7_________8_________9_________10

No Pain Mild Moderate Severe Emergency Room

Mark the **Worst** Pain:

0________1________2________3________4_________5_________6_________7_________8_________9_________10

No Pain Mild Moderate Severe Emergency Room

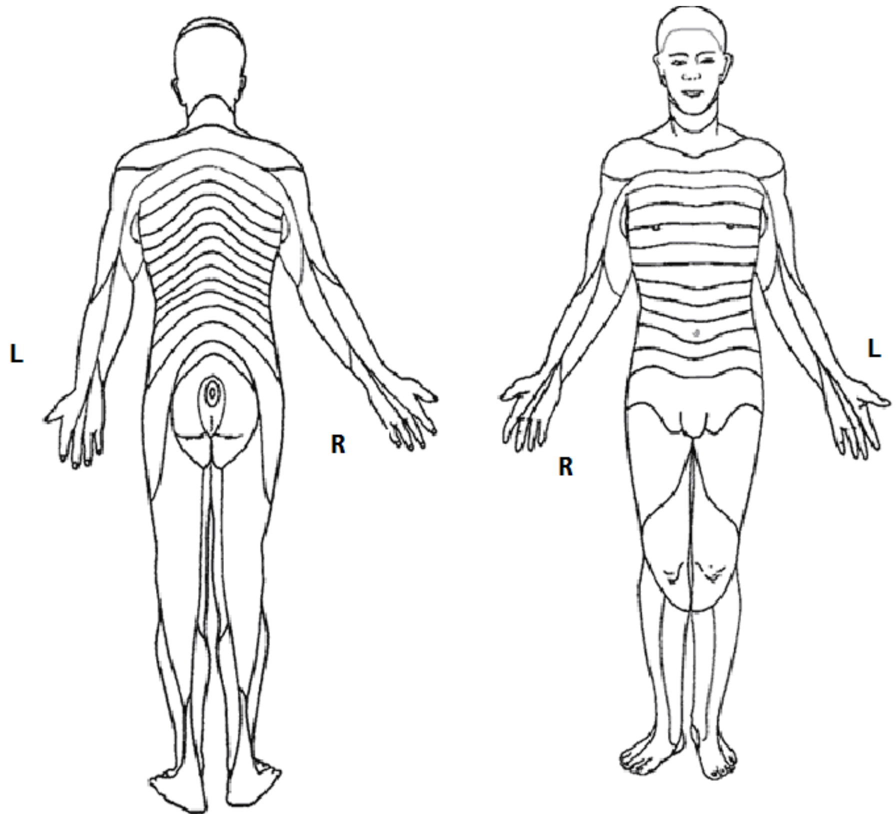
Mark the **Current** Pain:

0________1________2________3________4_________5_________6_________7_________8_________9_________10

No Pain Mild Moderate Severe Emergency Room

Pain Diagram

Use a pen to mark the location of your pain on the diagram.



Assignment of My Benefits

IMPORTANT: All information must be completed or we will NOT be able to do the courtesy of dealing directly with your insurance plan.

1. Policy Info

Patient Name:_______________________________________ ID#__________________ DOB ________

KP Policy :____________________________________ Group ________________________________

Insured Name (if other than patient): _________________________________ Insured Date of Birth ___________

Your relationship to the Insured: ☐ Parent ☐ Spouse ☐ Other _________________________

Claim # ____

Healthcare Provider info

*I hereby instruct and direct **Kaiser Permanante** insurance company to pay by check made out to the "**Hands-On-Care**" to the right and mailed to the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.*	**Hands-On-Care** 499 Blossom Hill Rd, San Jose, Ca 95123 Tel:408-268-8536 Fax:408-268-8727 **Tax ID: 26-1773301**

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

☐ A photocopy of this Assignment shall be considered as effective and valid as the original.

☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

☐ I authorize the use of this signature on all insurance submissions.

☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.

☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I understand,that I am financially responsible for all charges whether or not paid by insurance.

Dated this ______ day of________________, 20_____ .

_______________________________ _________________________ _________________________

Signature of Policy Holder Witness Signature of Claimant, if other than policy holder